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Unraveling Sex Trafficking through Screening and Referrals

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Executive Summary

Title: Unraveling Sex Trafficking through Screening and Referrals

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Introduction of the problem

Human trafficking is a form of modern-day slavery; sex trafficking is one form of human trafficking. As of June 30, 2018, 2,529 calls were made to the National Human Trafficking Hotline that referenced Missouri and 660 cases were initiated since 2007 (National Human Trafficking Website, 2017). These phone calls do not include calls to local law enforcement. In 2017, the OB/Gyn clinic at Barnes-Jewish Hospital in St. Louis, Missouri saw approximately 20,000 patients. Of these patients roughly 85% were Medicaid eligible, which is one marker of a vulnerable population. The OB/Gyn clinic staff is comprised of registrars, secretaries, registered nurses (RN), licensed practical nurses (LPN), medical assistants (MA), phlebotomist and social work (SW). A perinatal mental health service also practices in the same office, which includes SW and licensed professional counselors (LPC). Healthcare staff are in key positions to identify and address the needs of victims of human trafficking.

Literature Review

According to the federal Trafficking Victims Protection Act (TVPA, Section 103, 2000), sex trafficking is defined as a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age. It is important to emphasize that under U.S. federal law, any minor under the age of 18 years of age involved in a commercial sex act is a victim of sex trafficking, regardless if the trafficker used force, fraud, or coercion (Polaris, 2017). In previous U.S. studies, as much as 88% of trafficking victims

reported encountering the healthcare system during their trafficking experience (Macias-Konstantopoulos, 2016).

Sex trafficking can cause a plethora of psychological and physical trauma (Lederer & Wetzel, 2014; Richards, 2014). Healthcare workers are unlikely to screen for trafficking without prior training; this may lead to erroneous perceptions of the scope of the problem (Macias-Konstantopoulus, 2013; Ross, Dimitrova, Howard, Dewey, Zimmerman & Oram, 2015). Sex trafficking myths must also be addressed during training. After completion of human trafficking training, healthcare workers reported increased awareness of trafficking and an increased intent to screen (Ross, et al.). Screening must follow a trauma informed framework to prevent further traumatization (Shimmin, 2017).

Project Methods

The purpose of this project was to increase staff confidence with sex trafficking screening and to complete appropriate referrals to address the identified needs. Institutional Review Board (IRB) approval was not required for this project. The presentation built on a prior sex trafficking awareness presentation that was conducted approximately one year prior to this training. A brief review of signs and symptoms were completed, then nuances of trafficking screening and myths were addressed. The presentation concluded with the introduction of a sex trafficking specific resource binder and review of the referral process. An adult screening tool from the National Human Trafficking Training and Technical Assistance Center and a Six-item adolescent screening tool were reviewed. The training emphasized the importance of screening being a process and not simply a checklist. An 18 question post-training survey was administered following the training. The questionnaire consisted of Likert scale questions and a space at the end for comments.

A total of 23 participants, which included registration staff, secretaries, phlebotomists, RNs, LPNs, medical assistants, NPs and SW, attending the training. Of those, 19 completed the post-training survey. Further evaluation was completed at a one-month post-training focus group. The focus group consisted of three RNs, one secretary, one NP and one SW. The focus group began with a few open-ended questions followed by an opportunity for discussion.

Evaluation

Staff feedback on the day of the training was overwhelmingly positive. Staff were engaged during the presentation with some discussions having to be moderated due to time constraints. Analysis of the post-training questionnaires supported the positive tone. Of the 19 participants that completed surveys, 17 marked agree or strongly agree to the question of understanding the term human trafficking. 17 also marked agree or strongly agree to a question pertaining to confidence with screening for physical safety. The most significant variation in scoring occurred with questions regarding mandatory reporting, adequacy of time to screen and the necessity of reporting a self-identified sex worker.

More SW participants felt that they had enough time to complete trafficking screening than RN/LPN/NP participants. The concept of mandatory reporting also demonstrated variation along professional designations. More SW staff than RN/LPN/NP staff marked agree/strongly agree to the question of reporting an adult disclosed case of sex trafficking, even if the patient declined a referral. A SW participant during the training commented that she felt an obligation to others that may be being trafficked by the same trafficker as the patient in question, but do not have access to reporting. A question regarding reporting of a self-identified sex worker received the most neutral, neither agree or disagree, responses.

Eight out of the 19 completed surveys included comments. The comments were all positive regarding the impact of training. One SW participant wrote “I learned a lot. I feel more comfortable screening”. Two commenters noted concerns regarding the referral process. One wrote “Great presentation. If you are going to expand on it, please talk more about the referral process and what it looks like”. Another wrote “I think the presentation was very informative and well put together. My only concern is after identifying a trafficking patient that I won’t know how to adequately or properly take care of the patient”.

Feedback collected during the one-month post-training focus group echoed these concerns. Focus group participants reported that after training they started noticing trafficking red flags and were more insistent about ensuring patient privacy so that they could conduct screening. One group member stated that prior to training she had not consider asking a same-gender support person to step out during safety screening. Focus group members recommended adding trafficking training to annual staff competencies and new employ orientation. Group members also wanted more information regarding referral resources.

The main limitation of this project was staff turnover. During the project period, our office experienced significant changes in SW, RN, secretary and management staff. It was very challenging to create a succinct screening and referral process when the key staff kept changing.

Impact on Practice

The immediate impact on practice was that the staff started ensuring patient privacy in order to conduct safety screening. The staff also began noticing red flags and then referring those patients to SW for a more thorough screening. Approximately one month after the training, a trafficking patient was identified and referred to SW. The NP caring for the patient made a referral to the National Human Trafficking Hotline (NHTH). The NHTH staff member stated

that our office must have received thorough trafficking awareness training because we handled the case in a textbook manner. The predicted long-term impact is to build on this training and expand the training to all areas of the medical center. The goal is to include human trafficking training in annual staff education. Ongoing success of this project will require more discussion of the referral process and development of procedures to ensure process fidelity amid changes in staffing.

Conclusions

Healthcare workers are in key positions to identify and provide appropriate referral services to victims of sex trafficking. Comprehensive training increases staff confidence with screening and increases intent to screen. In future trainings, I would recommend tailoring the training to the area of focus. For example, screening for trafficking by an RN in an operating area will have a different focus than screening conducted by a registration staff in the outpatient setting. The principles are the same, but the focus and specific process should be nuanced. Screening processes should begin with nationally developed standardized screening tools and then modify the process to fit the department. Healthcare workers that screen, identify sex trafficking victims and refer those patients for needed services will greatly improve the long-term outcomes for those patients.

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